c. **Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)**

~~FQHC and RHC reimbursement will adhere to section 1902(a) of the Social Security Act as amended by Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA). The reasonable cost-based reimbursement requirements for FQHC/RHC services previously described at paragraph (13)(C) are repealed and instead A~~a Prospective Payment System (PPS) consistent with paragraph (15) payment described in section 1902(aa) of the Act for FQHCs/RHCs was~~ill be~~ implemented and took~~. The Nevada Medicaid Prospective Payment System (PPS) is to take~~ effect on January 1, 2001.

Prospective Payment System (PPS) Reimbursement for Existing Facilities

On ~~Beginning~~ January 1, 2001 the State began~~will~~ paying current FQHCs/RHCs (including "FQHC look alike clinics") based on a PPS rate methodology, per CMS requirements. The baseline for a PPS was~~ill be~~ set at 100 percent of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the FQHC/RHC fiscal years 1999 and 2000, adjusted to take into account any reported increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Medicaid-covered services that are considered to be FQHC/RHC services are those services that were identified and approved to be provided by the facility as it applies to HRSA in order to be deemed as an FQHC/RHC facility.

After some FQHC facilities began providing Dental services, the State began paying for these services on a fee-for-service basis due to limitations in our MMIS system **and in agreement with the affected FQHCs**. After 2010, FQHC facilities that provided Dental Services requested that the State provide Service Specific PPS rates **based on costs** instead of continuing to pay for dental services on a fee-for-service basis. **The process used to determine these Service Specific PPS Rates is outlined under the Alternative Payment Methodology heading below. Each FQHC facility location will be considered by the type of services offered at that individual facility location and the appropriate Service Specific PPS Encounter Rates and codes will be determined and assigned to each location.**

Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous year, increased each October 1st (FFY) by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (4) of the Social Security Act~~, and adjusted to take into account any reported increase (or decrease) in the scope of services furnished by the FQHC/RHC during that fiscal year~~.

Service Specific Prospective Payment System (PPS) Reimbursement for New Facilities

Newly qualified FQHCs/RHCs after Federal fiscal year 2010 will have initial payments (interim Service Specific PPS rates) established either by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads and/or similar scope of services or based on an average of rates for other FQHC/RHC clinics throughout the State.

For FQHCs that provide Medical, Mental Health and Dental services, Service Specific PPS rates **will** be established for each separate service **type**.

Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, the initial interim payments of the FQHC/RHC will be cost settled and any over or under payments will be reconciled~~determined~~ and the **S**ervice **S**pecific PPS rate(s) will then be established ~~based on actual cost to provide those services for their first full year~~. The per visit Service Specific PPS rate(s) will then be adjusted annually every October 1st beginning at the next federal fiscal year by the percentage change in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (4) of the Social Security Act, for that calendar year as published in the Federal Register~~, adjusted to take into account any reported change in scope of services, reported and requested during that year~~. All required documentation of actual costs for the first full year of providing services must be furnished to DHCFP no later than six (6) months after completion of the first full year of services. If the required documentation is not received within six (6) months after the completion of a full year of services, the annual MEI adjustments will be suspended until such time as the documentation is received and an actual Service Specific PPS rate is determined.

~~Rebasing:~~ Baseline PPS rates will not be subject to rebasing after their initial computation unless authorized by congress. The actual costs related to any reported change in scope of services **for each specific service type** will be calculated (based on a full year of providing those new services) and an adjustment to the baseline PPS rate will be made.

Alternative Payment Methodology(APM) Reimbursement-Service Specific Encounter Rate

For ~~the period beginning January 1, 2001 and ending September 30, 2001, and for~~ any fiscal year after~~beginning with~~ FY 2002, a State may~~, in reimbursing an FQHC/RHC for services furnished to Medicaid beneficiaries,~~ use a methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is at least equal to the amount to which the center or clinic is entitled under the **original** Medicaid PPS. Third, the methodology must be described in the approved State plan.

Beginning in 2012, for the two existing FQHCs, the State **in accordance with the providers request,** reviewed cost data for all applicable services **(medical, dental and mental health, where applicable)** and service specific PPS rates were established for each FQHC facility for the separate service types being provided **as agreed upon by all parties. The same cost review process that was used to set the original PPS Encounter rates was used to set the Service Specific PPS Encounter rates. The Service Specific PPS Encounter rates will be considered and reviewed as separate entities for any updates (MEI) or changes in scope as their costs were reviewed separately in order to establish their Service Specific PPS Rates. Medicaid will pay each facility only for the specific service types that they deliver based on the encounter codes submitted on the claim.**

Effective October 1st (FFY) of each year after an APM rate has been established, for services furnished on or after that date, DHCFP will adjust the APM rate by the percentage increase in the MEI applicable to primary care services as published in the Federal Register for that calendar year, which will account for basic cost increases associated with providing such services.

Change in Scope of Services

Service specific PPS/APM rates may be adjusted to take into account any requested, documented and approved increase (or decrease) in the scope of services furnished by the FQHC/RHC in any given fiscal year **for each specific service type.** The FQHC/RHC must submit a written request **detailing the Change in Scope** to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the Change in Scope of Services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a Change in Scope of Services was received by DHCFP. Documentation and notification to support an increase or decrease in the scope of services is the responsibility of the provider **and must specify the changes to each service type which will be reviewed independently.**

An FQHC/RHC requesting a **service specific** rate adjustment for changes in scope of services must submit data/documentation/schedules that substantiate the changes in scope and the related adjustment of reasonable costs following accepted Medicare principals of reimbursement.

An interim rate will be determined using the first three months of actual cost data which includes the new services available from the provider. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual new costs for a full year of service and an adjustment will be made to the service specific PPS/APM **rate**. Adjustments to the service specific PPS/APM rate for qualified/approved changes in scope will be based on Medicare Cost Reimbursement methodology, allocating costs related to patient care based ~~up~~on a provider's audited and approved cost~~harge~~s for the change in scope of services. The service specific PPS/APM rate adjustment will then be determined by dividing the ~~Medicaid~~ allocated costs by the number of total ~~Medicaid~~ visits for the given time period.

A Change in Scope of Services has been defined as a change in the type, intensity, duration and/or amount of covered Medicaid services (covered under the Medicaid State Plan and approved by CMS) that meet the definition of FQHC/RHC services as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act. General increases or decreases in costs associated with programs that were already a part of an established PPS/APM rate do NOT constitute a Change in Scope. The annual MEI adjustment is intended to cover these general increases. **A Change in Scope** must meet all of the following requirements ~~are met~~:

- The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act.

- The cost is allowable under Medicare reasonable cost principals set forth in 42CFR Part 413.

- The net change in the FQHC/RHC's per visit **service specific PPS** rate must equal or exceed 4% for the affected FQHC/RHC site**(s)**. For FQHC/RHC's that filed consolidated cost reports for multiple sites to establish the initial Prospective Payment reimbursement rate (PPS), the 4% threshold will be applied to the average per visit rate of all sites **that provide that specific service** for the purposes of calculating the cost associated with a **service specific** scope of service change. "Net change" means the per visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year **for the specific service type**.

A Change in Scope of Services is further defined as one ~~includes any~~ of the following:

- A change in the types of services offered, i.e., the addition of dental services, may qualify as a Change in Scope which may warrant an adjustment to the Service Specific PPS/APM rate or the establishment of a new Service Specific PPS/APM rate.

- A change in intensity/duration or character of services offered by an FQHC/RHC attributable to changes in the types of patients served may qualify, such as services to patients with HIV/AIDS or other chronic diseases and other special populations requiring more intensive and frequent care. These changes must be reasonably expected to span at least one year.

- **A change in the amount of services offered, i.e., previously only offered dental cleaning and exams/x-rays and now offering more advanced services such as root canals or extractions. Simply providing more visits of the same service type does not constitute a change in scope.**

- A change in the magnitude, intensity or character of currently offered services, demonstrated and documented by an increase or decrease in the patient volume of certain high risk populations that require more intensive and frequent care, which may reasonably be expected to span at least one year may qualify.

- A change in the type, intensity, duration or amount of service caused by changes in technology and medical practice used may qualify.

If a Change in Scope rate increase is denied, the provider may request a formal Rate Appeal from DHCFP. Refer to Medicaid Service Manual (MSM) Chapter 700 for Rate Appeals.

Definition of a "Visit"/"Encounter"

A "visit" or an "encounter" for the purposes of reimbursing FQHC/RHC services is defined as face-to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient for the same service type. A single payment will be made for each "visit" or an "encounter" regardless of the type of service.

Effective February 6, 2016, DHCFP will allow FQHC's reimbursement for up to 3 service specific visits per patient per day to allow for a medical, mental health and dental visit to occur on a single day for the same patient. The interim Service Specific PPS Encounter rate for mental health services

will be the current rate established for each FQHC for a medical visit or an amount agreed to between the specific FQHC and DHCFP. After one year of providing up to three visits per patient per day, the payments of the FQHC will be cost settled and any over or under payments will be reconciled and the Service Specific PPS rate will be established. This review of actual costs **for each specific service type** will be completed by DHCFP or an entity contracted by DHCFP.

Qualified Health Professional

To be eligible for PPS/APM reimbursement, services must be delivered exclusively by one or more of the following licensed Qualified Health Professionals (QHP) or a provider working under his or her direct supervision: Pphysician, Osteopath, Podiatrist, Pphysician's Aassistant, ~~nurse practitioner~~Advanced Practice Registered Nurse, Certified Registered Nnurse Aanesthetist, Certified Nnurse Mmidwife, Cclinical Ppsychologist, Cclinical Ssocial Wworker, Ddentist or Ddental Hhygienist.

Documentation Required to Support a Request for Change in Scope of Services

- Year End Payroll Reports for identified time periods
- Trial Balances for all Revenues and Expenses for identified time periods
- Grouping Schedule/Mapping of Trial Balance Accounts to the Cost Reports
- Detailed General Ledger with Vendor Information for identified time periods
- HRSA Notice of Awards for all approved Changes in Scope of Services
- Claims reports showing Unique Patient Visits, DOS, Procedure Codes, Service Facility ID#, Amount Paid and Payor
- Other Data ~~Items~~ as Deemed Necessary

Other Payment Adjustments

FQHC/RHC's may request other payment adjustments in the event of extraordinary circumstances, not otherwise reimbursed by other sources, including but not limited to acts of God; acts of nature; acts of terrorism and acts of war. However, if an FQHC/RHC's existing Service Specific PPS/APM rates are ~~is~~ sufficient to cover its overall costs, including those associated with the extraordinary circumstances, other payment adjustment is not warranted. The FQHC/RHC must show that its Service Specific PPS/APM rates are ~~is~~ not sufficient to cover the **additional** costs associated with the extraordinary circumstance. The adjusted rate will only apply to the extent, and only for the period of time, that the additional costs for the event are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation (FMAP). DHCFP will work with the provider to gather the appropriate data at the time of the incident after a written request for an adjustment is made by the Provider.

Record keeping and Audit

All participating FQHC/RHC's shall maintain an accounting system which identifies costs in a

manner that conforms to generally accepted accounting principles, Medicare principals of reimbursement and must maintain documentation sufficient to support all cost/visit data.

The DHCFP, its fiscal agent or a designated and contracted financial entity may conduct periodic on-site or desk audits of all cost data, including financial and statistical records of the FQHC/RHCs.

FQHC/RHCs must submit information (statistics, costs and financial data or other data) as deemed necessary by the DHCFP or its fiscal agent. Failure to submit requested documentation may result in denial of a rate adjustment request.

If a rate adjustment increase is denied, the provider may request a formal Rate Appeal from DHCFP. Refer to Medicaid Service Manual (MSM) Chapter 700 for details on Rate Appeals.

The DHCFP will conduct one audit annually (at a minimum) to the claims submitted by the FQHC/RHC for supplemental payments.

Supplemental Payments for FQHCs/RHCs

FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly or monthly (as agreed upon between the provider and the state) supplemental payments for furnishing such services, that are a calculation of the difference between the payments the FQHC/RHC receives from the MCE(s) for all qualified Medicaid FQHC/RHC visits and the payments the FQHC/RHC would have received under the Service Specific ~~BIPA~~ PPS methodology or APM.

At the end of each payment period, the total amount of MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS/APM methodology. If the amount exceeds the total amount of MCE payments, the FQHC/RHC will be paid the difference, if the amount is less, the FQHC/RHC will refund the difference to DHCFP. The FQHC/RHCs must provide sufficient documentation (as requested) to DHCFP to facilitate supplemental payment calculations. If the required documentation is not provided to support the supplemental payment, future supplemental payments may be suspended.

Documentation Required to Calculate/Support Supplemental Payments

The FQHC/RHC will submit an ~~written/~~electronic request for supplemental payment which will contain at least the following information for each line item of every qualified encounter during the reporting time period (Quarterly or Monthly): ~~Servicing and~~ Medicaid Billing Provider ID#~~s~~, Recipient MCE ID Number, Recipient Medicaid ID Number, Date of Service, ~~CPT~~Procedure Code(s), MCE Name, Total Billed Amount, MCE Paid Amount, ~~and~~ Total Amount Paid, and Recipient Date of Birth. The FQHC/RHC will submit claim data for supplemental payment no later than thirty days after the end of the reporting period agreed upon with the DHCFP (Quarterly or Monthly). Any discrepancy found in the audits will be adjusted based on the audit findings.